STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004779	A. BUILDING: _____ B. WING _____	C 08/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT DUNN HOSPITAL INC	1600 23RD ST BEDFORD, IN 47421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of one (1) State complaint. Complaint number: IN00140966 Substantiated; No deficiencies related to allegations are cited. Date of survey: 8/26/14 Facility number: 004779 Surveyor: Marcia Anness, RN Public Health Nurse Surveyor St. Vincent Dunn Hospital is in compliance with 410 IAC 15-1.6.2, Emergency Services, Hospital Licensure Rules. QA: claughlin 10/31/14	S 000		